DOCUMENT RESUME

ED 288 161 CG 020 335

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TITLE Agoraphobia and Paradigm Strain: A Family Systems Perspective.
PUB DATE Mar 87
NOTE 18p.; Paper presented at the Annual Meeting of the Southeastern Psychological Association (33rd, Atlanta, GA, March 25-28, 1987).
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Anxiety; *Counseling Techniques; *Family Influence; Models; *Systems Approach
IDENTIFIERS *Agoraphobia; *Family Systems Theory

ABSTRACT

Agoraphobia is an increasingly common, often chronically incapacitating anxiety disorder. Both behavior therapy and pharmacotherapy can be effective in reducing the intensity of agoraphobic symptoms. There are promising new developments, however, from a family systems perspective. Researchers are finding that an agoraphobic's marriage and family relationships are profoundly relevant to understanding this disorder and the long-term results of treatment. Four empirically supported propositional statements are relevant to the role of family interactional factors in agoraphobia: (1) agoraphobia occurs in highly complementary relationships, particularly marriages organized according to traditional sex-roles; (2) close relatives of agoraphobics, particularly their spouses, often are reported to have equally serious problems; (3) agoraphobic symptoms arise in response to real or anticipated changes in vital relationships and function to preserve former patterns; and (4) symptomatic improvement may have negative repercussions in the family system. Two interactional systems models which most readily accommodate these findings are the functional/structural view and the accidental/sequential model. Therapists must address the question of which levels of system-individual, couple patient-family, or patient-family-helpers, have priority for intervention under what circumstances. Implicit in the interactional systems view is the idea that broader levels of context are most relevant. (NB)

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AGORAPHOBIA AND PARADIGM STRAIN:

A FAMILY SYSTEMS PERSPECTIVE

Agoraphobia is an increasingly common, often chronically incapacitating anxiety disorder recognized in DSM III (American Psychiatric Association, 1980). The incidence of agoraphobia in our society is relatively high (.5% according to DSM III) and rising. The disorder has received considerable attention in the professional literature and in the popular media, as phobia clinics and self-help organizations proliferate across the country.

There is substantial evidence that both behavior therapy and pharmacotherapy can be effective in reducing the intensity of agoraphobic symptoms. In fact, phobic disorders have been hailed as "psychotherapy's greatest success story" (Rosenhan and Seligman, 1984). Not surprisingly, the dominant contemporary theoretical models of agoraphobia are rooted in biopsychiatry and learning theory-paradigms which lead clinicians to focus on the individual patient rather than the context of intimate relationships in which such symptoms occur. From a family systems viewpoint, however, there are promising new developments: Researchers and clinicians, primarily behaviorists, are finding that the agoraphobic's current marriage and family relationships are profoundly relevant to understanding this disorder and the long-term results of treatment.

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One purpose of this paper is to review these developments which, in our view, strain the linear, individualistic paradigms from which they have arisen. Another is to recast existing observations and evidence into an interactional paradigm based on cybernetic and systems ideas. We propose that interactional models of agoraphobia not only account for much of the current data, but have implications for treatment not derivable from competing paradigms.

The Paradigmatic Lens

Despite general agreement on the descriptive clinical picture in agoraphobia, theoretical formulations vary widely. It is difficult to overestimate the extent to which the paradigmatic lens through which we view a disorder influences what we pay attention to and what we do not. This point is especially important when family interactional factors are considered since the more established psychodynamic, biological, and behavioral paradigms effectively constrain how we think about family interaction, and sometimes distract attention from such influences entirely. From the perspective of interactional family systems a most fundamental constraint stems from the assumption that agoraphobia is a disorder of one person.

Research has shown that antidepressant medication can be effective in controlling the panic attacks assumed by biological theorists to be the core of the agoraphobic syndrome. Exposure based behavioral therapies have been reported to be equally effective. In a review of behavioral outcome research, however, Barlow and Mavissikalian (1981) have pointed out that while 60-75% of treated phobics improve, only 4-18% become totally symptom-free. These statistics, furthermore, are based on patients who completed treatment; yet agoraphobic patients are noted for

dropping out of therapy, with attrition rates in some studies as high as 30%. Viewed in this way, outcome data are less impressive since barely half of the agoraphobics treated in research settings may be getting better. To complicate the outcome picture further, there are reports that exposure therapies may be less effective for male agoraphobics than for females (Guidano and Liotti, 1976). In any case, it is premature to conclude that the therapeautic book on agoraphobia is closed.

Given the constraints of current individually focussed paradigms, it is surprising how often factors other than individual patient behaviors or characterx have been reported as irrelevant to treatment in the literature on agoraphobia. It has been repeatedly observed, for example, that the disorder occurs in highly complementary, dominant-submissive relationships; that married patients show an exaggerated dependence on a "well" spouse who appears to be reinforced by this dependence (Agulnik, 1970; Bergner, 1977); and that symptomatic improvement is often accompanied by increased marital conflict or the appearance of symptoms in the spouse (Milton and Hafner, 1979; Hafner, 1984). Some therapists have even suggested that the agoraphobic syndrome may only occur in patients who feel trapped in a difficult interpersonal relationship (Goldstein & Chambless, 1981). Others recommend that the spouse should routinely be included in exposure treatment as a co-therapist (Vandereycken, 1983) and for some couples at least, this improves outcome (Barlow, O'Brien and Last, 1984).

In the next section of this paper we will outline four empirically supported propositional statements and supporting evidence about the role of family interactional factors in agoraphobia.

1. Agoraphobia occurs in highly complementary relationships, particularly marriages organized according to traditional sex-roles. Webster (1953) cited evidence over thirty years ago that phobic systems are part of a mutual caretaking strategy in which the wife's dependency needs are met by the husband who in turn is helped to feel competent and ignore his own problems. Many authors have reported evidence and observations of patterns of highly complementary relationships, e.g., interactions characterized by exchanges of opposite behavior (dominance-submission, helplessness-nurturance) in the marriages of agoraphobic patients (Agulnick, 1970; Bergner, 1977; Fodor, 1974; Goodstein & Swift, 1977; Hafner, 1977; Liotti & Guidano, 1976). In cases where agoraphobia occurs outside of a marriage, interaction around the symptoms has also been reported to be highly complementary (Goldstein, 1982; Guidano & Liotti, 1983).

2. Close relatives of agoraphobics, particularly their spouses, often are reported to have equally serious problems. Many of the clinical reports cited above also make reference to apparent dysfunction of the patient's spouse or other family members. Husbands of agoraphobic women, for example, have been variously described as rigid, detached, jealous, insecure, sexually inadequate and neurotic (Bergner, 1977; Goodstein and Swift, 1977; Hafner, 1970; Quaddrio, 1984) and some mothers of agoraphobic daughters have been reported to be remitted agoraphobics themselves (Goldstein, 1982). Agulnik (1970) has reported high correlations between neuroticism scores of spouses and agoraphobic patients as has Hafner (1977).

3. Agoraphobic symptoms arise in response to real or anticipated changes in vital relationships and function to preserve former patterns. There is evidence that the onset of agoraphobia is correlated with actual or portended shifts in intimate relationships, some of which are inevitable in the family life cycle. Guidano and Liotti (1983) report that agoraphobic symptom onset most commonly occurred: 1) just before or shortly after marriage; 2) when the patient is about to leave home or become more independent; 3) when new affective relationships are formed outside the family; 4) after important life events such as a loss, the birth of a child, or a change in work that results in more or less independence for one partner; 5) during a marital crisis. Similar observations have been reported by Goldstein and Chambless (1978) who note that agoraphobic symptoms usually arise in a climate of interpersonal conflict often associated with one partner's moves to change a relationship. Liotti and Guidano (1976) have provided vivid descriptions of the manner in which symptom onset forestalls relationship change and preserves complementary, albeit unsatisfactory, interaction patterns.

4. Symptomatic improvement may have negative repercussions in the family system. The idea that symptoms provide interpersonal benefits or "secondary gains" for the patient is not new. Interactional formulations, on the other hand, emphasize the system-stabilizing protective function of symptoms. Clinical reports tend to confirm this view. Spouses reportedly sabotage treatment (Emmelkamp, 1974; Hafner, 1982), and symptomatic improvement is often accompanied by increased marital discord and dissatisfaction (Goodstein and Swift, Hand and Lamonstagne, 1976; Milton and Hafner, 1979; Hafner, 1984). Of particular interest is a series of studies by Hafner and his associates. Hafner (1971) found that the

husbands of 33 patients, who improved following brief exposure therapy, evidenced increased scores on measures of neuroticism concommitant with improvement in their wives' symptoms. In a number of cases, the husband became symptomatic himself after the wife improved (Hafner, 1977). Later, when some of the wives relapsed, their husbands improved. Similar observations of mother-daughter dyads have been reported by Goldstein (1982). In a partial replication (Milton and Hafner, 1979), 9 of 18 marriages appeared to be adversely affected by symptomatic improvement in the identified patient. Furthermore, marital dissatisfaction has been reported to be predictive of outcome of exposure treatment (Blend and Hallam, 1981) and relapse (Milton and Hafner, 1979). In a recent study, Hafner (1984) reported two distinct patterns of marital response to rapid improvement in the wives' symptoms following exposure treatment. In both groups continued symptomatic improvement at one-year follow-up depended on the couple's success in resolving "sex-role issues". At present, many behavior therapists acknowledge the role of marital dynamics in agoraphobia and recommend including the spouse in treatment (Vanderecycken, 1983). Experimental studies (Barlow, et. al., 1984) have confirmed that including the spouse as co-therapist improves outcome of behavioral treatment and may in some cases have more to do with positive outcome than exposure treatment per se.

The above findings seem to strain the linear, individualistic paradigm of learning theory from which most evidence of the role of family interactive factors in agoraphobia has been derived. If however, agoraphobia is conceptually localized within one person, interactive processes are split off as additional stress factors, motivating conditions, or sources of secondary gain -- and the relationship

(marriage) is important only insofar as it complicates the treatment process. From an interactive perspective this artificial separation of symptom from system is misleading. By formulating agoraphobia in terms of ongoing circular interaction patterns which both maintain and are maintained by the symptom, the unit of analysis and intervention expands to encompass not only the patient and his or her own self-defeating attempts to solve the problem, but the rule governed structure of the marriage (or family) relationship pattern itself.

Toward an Interactional View

The family interactional view is based loosely on cybernetics and systems theory. A key assumption is that regardless of how problems originate, they persist as aspects of current, ongoing interaction cycles. Cybernetic feedback processes provide a framework for understanding how symptoms are maintained, which from an interactional perspective is of greater interest than etiological speculation or linear notions of cause and effect. It is further assumed that problems exist not so much with a person as between persons -- that "symptoms" and interactive systems are inextricably interwoven. Thus, the interactional paradigm offers a different way of understanding what agoraphobia _is_. the fear of leaving home unescorted is less an abnormality of one person than an element in a recursive interaction process that requires several people for its maintenance.

Interactive systems models have evolved in two directions since the 1950s. One model we will refer to as a _functional/structural_ formulation and the other an _accidental/sequential_ formulation of interactive systems. Each model is "systemic" in its focus on ecological, cybernetic

formulations of problem maintenance, and "strategic" in that the therapist intervenes deliberately, on the basis of a specific plan, to resolve the presenting problem as efficiently as possible. We believe these models most readily accomodate the evidence reviewed above.

The functional/structural view assumes that symptoms "function" as stabilizing factors within an interpersonal system and maintain the relationship "structure" in which they occur. Negative feedback formulations (Haley, 1976; Minuchin, 1974) explain how family systems maintain stability through symptomatic behavior. In error-activated fashion, increases in one variable are linked to decreases in another, keeping some key system parameter within tolerable limits. Thus, increasing symptoms in one spouse may be associated with decreasing distress in the other; or the stablilizing variable could be a property of the marriage itself, e.g., the balance of power between spouses or the level of open conflict and aggression they express. When the agoraphobic's highly complementary, dominant-submissive marriage shifts toward symmetry, the appearance of symptoms may stabilize the relationship, though usually in a conflictual and unsatisfactory way. Such a formulation is consistent with the clinical observations and research findings discussed above. From a triadic view, symptomatic dysfunction reflects dominant alliances and coalitions which cross generation lines. There is little direct evidence linking triadic patterns to agoraphobia, but in our experience they are common.

Therapy based on the functional/structural model would attempt to shift the relationship structure toward symmetry at a dyadic level, and at the triadic level reinforce generational boundaries in such a way that the symptoms are disentangled from their hypothesized stabilizing functions.

Spouse aided co-therapy fits well with the strategic principle of respecting complimentarity and avoiding direct challenge of the problematic relationship.

The accidental/sequential model, developed by Fish, Weakland, Watzlawick (1982) and others, views problem maintenance as a simple positive feedback loop centering around well-intentioned but inappropriate attempts to solve the problem. More of the same solution leads to more of the problem and so on, in an over-escalating cycle. It is assumed that problems would be self-limiting were it not for the persistent but misguided problem-solving attempts of the people involved. Attention is focussed on the specific, highly repetitive sequences with the patient and his or her spouse, family and helpers engage in around the symptoms. In agoraphobia, oscillating patterns of reassurance, overprotection, hypervigilance or withdrawal often interlock with the symptoms -- any of which could be a target for strategic intervention. The goal would be to persuade the spouse(s)/helpers to do less of the same, using whatever rationale he, she or they would be likely to accept.

Systems, Levels and Paradigm

Therapists must address the question of which levels of system-individual, couple patient-family, or patient-family-helpers, have priority for intervention under what circumstances. When problem patterns are identified at several levels simultaneously, where is the best level to intervene? Implicit in the interactional systems view is that broader levels of context are most relevant. This implies, and our reading of the agoraphobia literature supports the view, that expanding the conceptual problem unit will be fruitful clinically.

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